Analysis Report No. AR 16-01

# Opportunities for Financial Benefit Using High Deductible Medical Plans:

## Analysis of State Employees' Medical Costs for Fiscal Year 2015

**January 12, 2016**


OFFICE OF THE

UTAH STATE AUDITOR

David Stringfellow, MPP — Chief Economist

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## Executive Summary

A large share of benefited State of Utah employees could have saved approximately $20 million by switching to higher deductible health plans while still receiving the same medical care. We asked the Public Employees Health Program (PEHP) actuaries to recalculate the costs employees would have paid utilizing the same health care services had they moved to a higher deductible health plan in fiscal year 2015. The recalculation showed that 12,660 members, 96% of members on the Traditional plan, could possibly have saved an average of nearly $1,500 had they switched to the STAR plan. Also, most of the 3,820 members on the STAR plan, or 6 out of 10 members, could have saved an average of about $1,200 had they switched to the Utah Basic Plus plan.

The bulk of the $20 million in savings that might have been realized by certain members comes from not paying premiums and the collection of contributions to Health Savings Accounts (HSA) for those who qualify. Members might also realize lower costs because cost sharing for some medical services are more advantageous than current co-pays. Though not considered in this analysis, it is also likely that additional savings would accrue to both members and PEHP as members become more involved in choosing more efficient medical care while meeting higher deductibles. The members who likely would not have realized savings by switching to higher deductible health plans would be some members with concentrated spending such as high prescription drug costs, some members who reached certain out-of-pocket maximums, and some members with high medical costs for an individual on a double or family plan, or some combination of these factors. Though this analysis only covers a simulation of claims for fiscal year 2015, the results appear to hold across significant plan changes between fiscal years 2015 and 2017.

## Recommendations

Based upon this report we recommend the following actions be taken:

1. Create HSA-equivalent options for members who do not qualify for HSA accounts under federal rules.
2. Align plan designs so that the STAR plan always results in a better financial outcome than the Traditional plan.
3. Target the Basic plan to low-risk employees or employees who are more risk tolerant.

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## Background

Each year, most State of Utah employees enroll in a medical plan provided by a nonprofit trust called the Public Employees Health Program (PEHP), a division of the Utah Retirement Systems (URS). There are three principal medical plans available for enrollment, each with a Single, Double, and Family option. Members must choose between two large networks of providers or pay an additional premium to gain access to both networks. The State of Utah contributes the same amount of money towards the premium in the Traditional plan (Traditional) as it contributes towards the combined premium and HSA employer contribution for the corresponding STAR plan (STAR) and the Utah Basic Plus plan (Basic). **Figure 1** contains a summary of other key plan features. **Appendices A and B** contain a summary of each plan's features over time.

### **Figure 1 -** State of Utah Medical Plan Features

| Medical Plan | Employee-Paid Premiums | HSA Contributions | Co-pays | Cost Share | Coverage |
|---|---|---|---|---|---|
| Traditional | Yes | No | Yes | 20% | Complete |
| STAR | No† | Yes‡ | No | 20% | Complete |
| Basic | No† | Yes‡ | No | 30% | Essential |

† - members who choose the Preferred Network must pay the extra premium to have access to both networks
‡ - in some situations, federal rules bar members from having access to a Health Savings Account

The networks available under these plans are:

- Summit Care – IASIS, MountainStar, University of Utah Hospitals & Clinics providers and facilities.
- Advantage Care – predominantly Intermountain Healthcare (IHC) providers and facilities.
- Preferred Care – providers and facilities of both the Advantage Care and Summit Care networks.

The premium paid by a member depends on their chosen plan and network and whether they receive Single, Double, or Family coverage. If a member elects a high deductible plan, they receive a set amount of employer-provided contributions to an HSA at the beginning and middle of a plan year. There are restrictions on how quickly members can move between plans in any given year, and members can only switch to Traditional or Basic if they are on the STAR plan.

*The State of Utah contributes the same amount of money towards the premium in the Traditional plan as it contributes towards the combined premium and HSA employer contribution for the corresponding STAR plan and the Utah Basic Plus plan.*

In 2006, the Utah Legislature passed HB76, High Deductible Health Plan Option. This directed PEHP to combine a high deductible health plan paired with a federally qualified health savings account. The Legislature passed HJR 29 in the 2009 General Legislative Session directing PEHP to equalize premiums among plans. In 2010, PEHP rebranded their high deductible health plan as the STAR plan. In 2012, the Legislature passed HJR 21 which directed the creation of a second high deductible health plan and a program to differentiate premiums or benefits. As a result, PEHP designed Utah Basic Plus. In order to encourage more members to move to the high-deductible STAR plan, an incentive was designed to eliminate member premiums and provide a large transfer to a member's HSA account to offset the high deductible.

## Analysis

The Office of the Utah State Auditor asked PEHP to evaluate alternative plan choices for the current 18,480 PEHP members employed by the State of Utah (members). Using actual fiscal year 2015 (FY2015) claims data, the actuaries re-evaluated the costs to members if they had switched from Traditional to STAR, or from STAR to Basic. **Figure 2** documents the percentage and number of members who were initially enrolled in each of the plans in FY2015. We did not evaluate those members who switched plans during FY2015. The analysis also capped the maximum difference among plans according to plan design features.

**Figure 2 -** Medical Plan Distribution of Member Enrollment FY2015

| Plans | Share of Members | Number of Members |
|---|---|---|
| Traditional | 71% | 13,160 |
| STAR | 21% | 3,820 |
| Basic | 1% | 200 |
| Switched Plans | 7% | 1,300 |

For the purposes of this analysis, it was assumed that all members could become eligible for a Health Savings Account (HSA) or equivalent benefit. This is a key feature of both STAR and Basic. In these plans, a portion of the employer-paid premium that would normally be sent to the risk pool within PEHP is diverted to the member's HSA. The member is then responsible for the cost of initial medical care they consume up to the high deductible amount. A member who does not receive these employer-paid contributions, and thus lacks these funds for initial care, is unlikely to adopt such a plan. In order to qualify for an HSA, a member must: 1) not be covered by a general-purpose flex account (FSA) or a Health Retirement Account (HRA), or the balances must be zero; 2) not be covered by another health plan, unless it is also an HSA-qualified plan; 3) not be covered by Medicare or TRICARE; 4) not be a dependent of another taxpayer. The PEHP actuaries could not incorporate these features into their analysis because there is no record of whether these conditions would apply to any given member on the Traditional plan.

## **Figure 3 -** Distribution of Network by Type of Plan

| Network | Member Plan: Single | Member Plan: Double | Member Plan: Family | Plan Share |
|---|---|---|---|---|
| Advantage | 10% | 15% | 37% | 62% |
| Summit | 7% | 10% | 20% | 37% |
| Preferred | 1% | 0% | 0% | 1% |
| **Member Distribution** | 18% | 25% | 57% | |

**Figure 3** shows the choices members made between networks and household coverage in FY2015. Roughly two-thirds were on the Advantage network, a third were on Summit and only 1% paid to be on both networks. A quarter of members are insured for two people on Double plans, 18% had Single coverage, and the remaining members (57%) were on Family plans. For purposes of this analysis, members remained in the same network and plan structure; the evaluation only altered whether a member would have moved from Traditional to STAR or from STAR to Basic.

Understanding the mechanics of the Traditional, STAR, and Basic plans helps one understand how savings are derived and distributed when members switch to high deductible plans. In addition to the simulation model that recalculates members' savings based on actual claim data, the following analysis presents hypothetical scenarios if state employees had moved between plans while receiving equivalent medical care. PEHP also duplicated this analysis to compare the costs members pay when consuming similar medical care. **Figures 4 through 6** show how member costs change under progressively increasing medical care. **Figure 6** adds cases in which Traditional remained more attractive to members. This involved members who had Family plans with an individual hitting one of the out-of-pocket maximums on Traditional. There were no systematic examples of when Single or Double plans were better under Traditional. This points to key differences in the structure of the Traditional and high deductible plans.

## **Figure 4 -** Hypothetical Spending by Medical Plan - Single

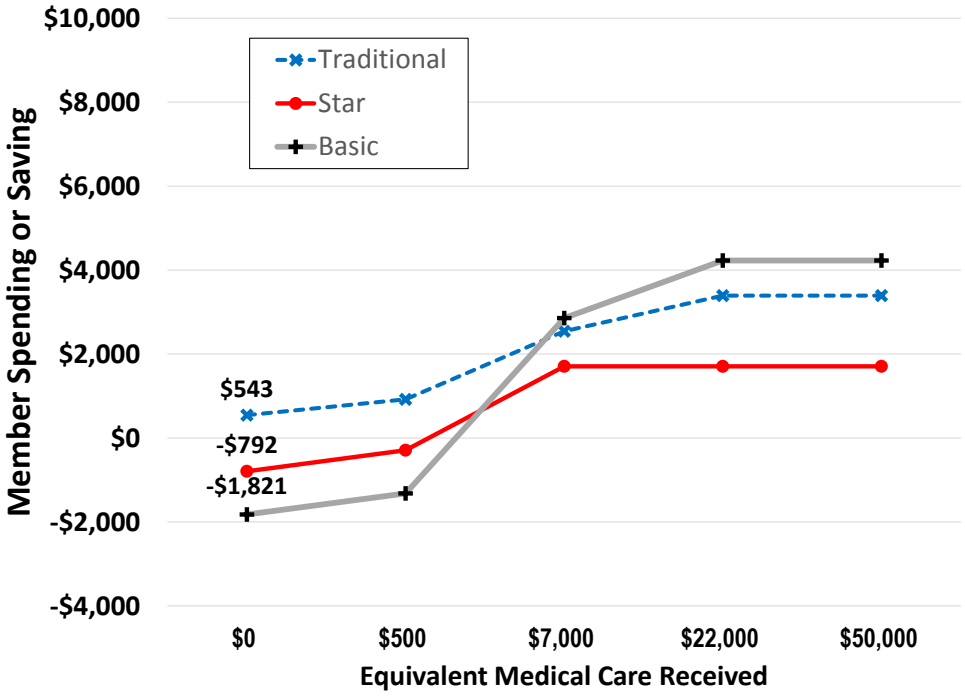


**Figure 5 -** Hypothetical Spending by Medical Plan - Double

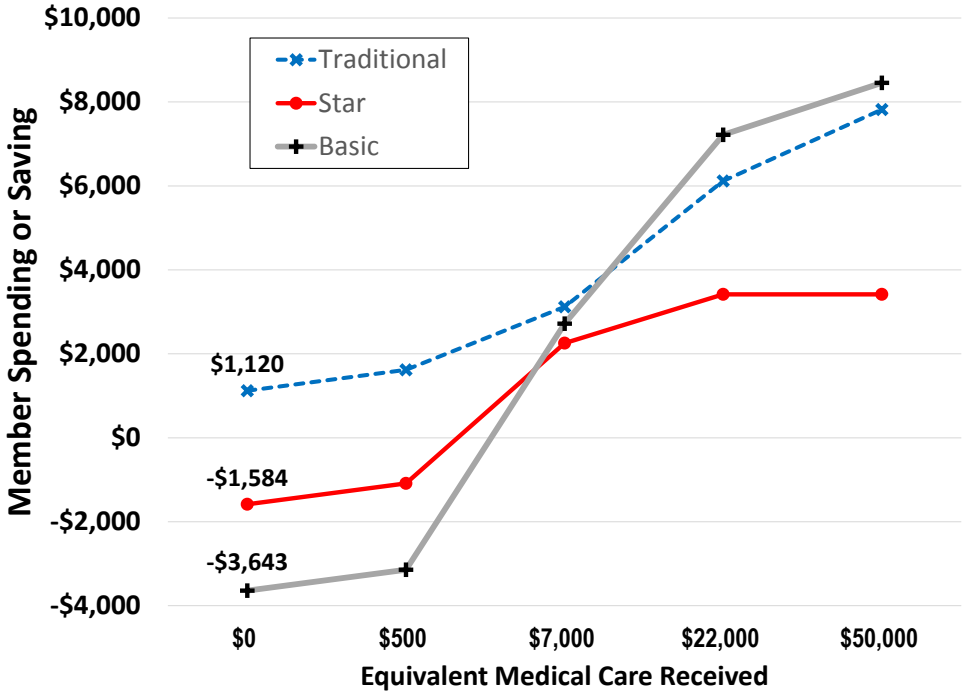
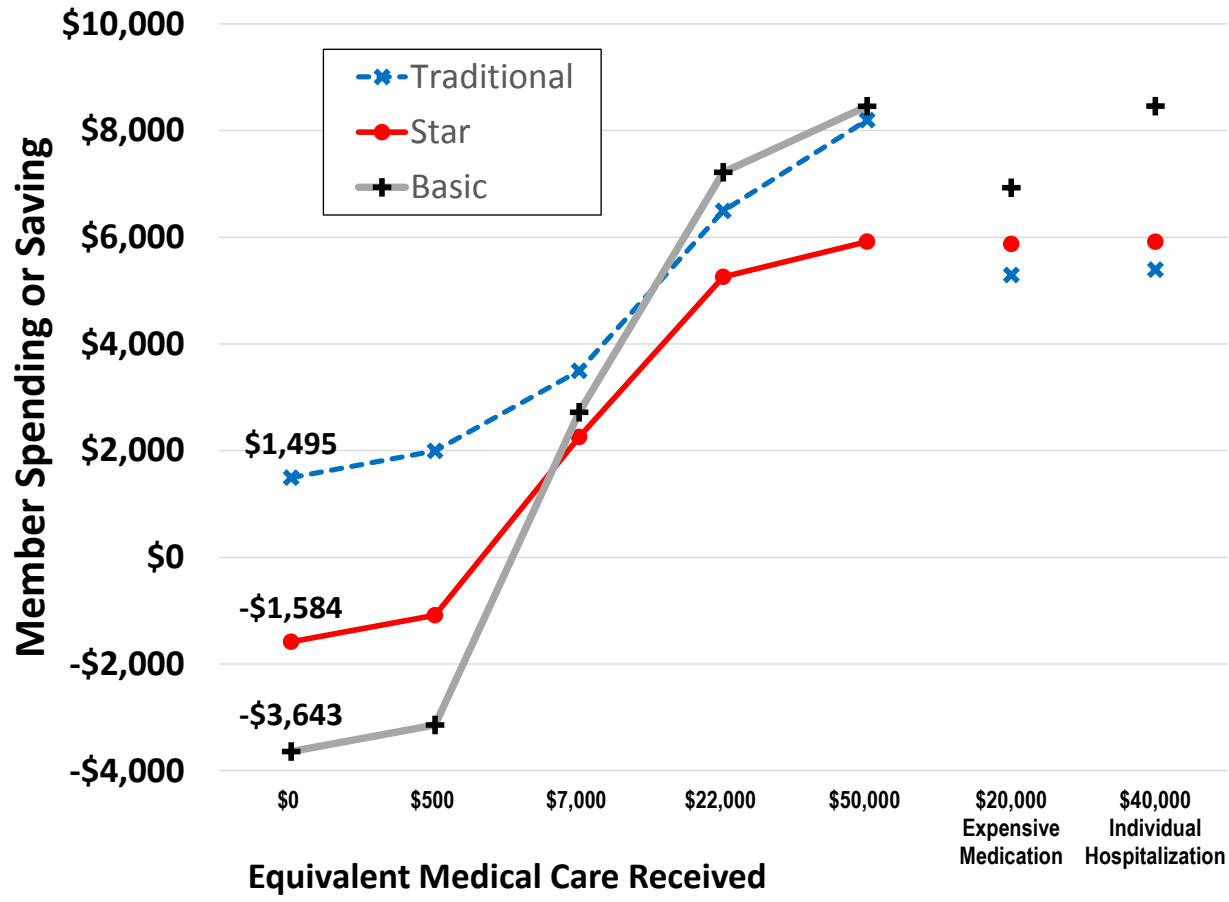



**Figure 6 -** Hypothetical Spending by Medical Plan - Family



A more detailed description of a few scenarios found in **Figures 4 through 6** shows the process by which members pay different total costs for the same medical care. The costs in each scenario are assumed to occur uniformly throughout the year. Detailed examples of the relative costs that members would pay under representative scenarios in using medical care are found in **Appendix C**.

In general this analysis shows how plan design can significantly affect the incentives for adopting particular plans. Member costs under STAR for equivalent medical care are almost always lower than the costs under Traditional. Members on Basic have more reward and risk—if medical spending is low then savings is high—while the opposite is true if costs are very large. Members who are better off under Traditional normally have high and concentrated costs in a particular class of spending that meets a deductible without much additional spending in other areas. The results shown in these graphs caused us to ask how this hypothetical analysis compared to actual historical experience. The analysis that follows shows that, overall, the costs and savings calculated using actual medical care spending of members matches the amounts calculated in these hypothetical circumstances.

## Findings

### Finding 1 – Over 96% of state employees with Traditional would likely save money switching to STAR, assuming all were eligible for an HSA (or equivalent) contribution.

**Figure 7 -** Financial Position of Members Had They Moved from Traditional to STAR

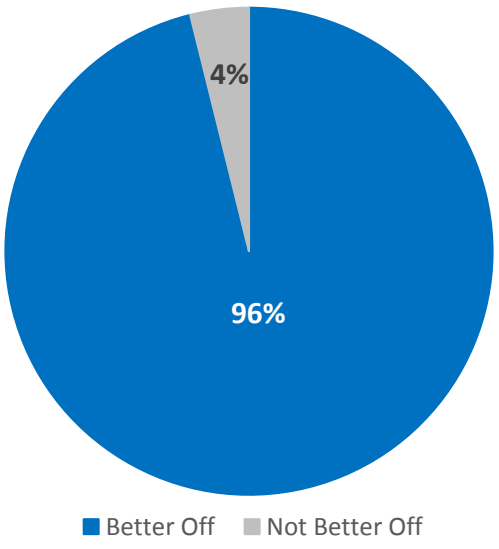



**Figure 7** shows that an overwhelming 96% of the 13,160 state employees who were on Traditional in FY2015 might have saved money by switching to the STAR plan. This aligns with the expectation formed in considering the hypothetical circumstances, but is based on actual claims data.

When describing large sums of savings spread out over a large member population, it is important to consider how the average member who switches plans compares with each member's particular circumstance. Many people are risk averse and are willing to sacrifice small fi-

nancial gains to avoid the possibility of large losses. However, it appears that many members are sacrificing large potential gains to avoid small losses most of them could never realize given the medical care they consume.

**Figure 8** shows that the 12,660 members who would likely benefit by switching from Traditional to STAR would save an aggregate $18.5 million, and the average member would save nearly $1,500 each year. The average employee in the State of Utah earns roughly $45,000. Members who switch from Traditional to STAR, while receiving identical medical care, could experience average savings roughly equivalent to a 3% pay raise.

**Figure 8 -** Savings of Members Better Off Moving from Traditional to STAR

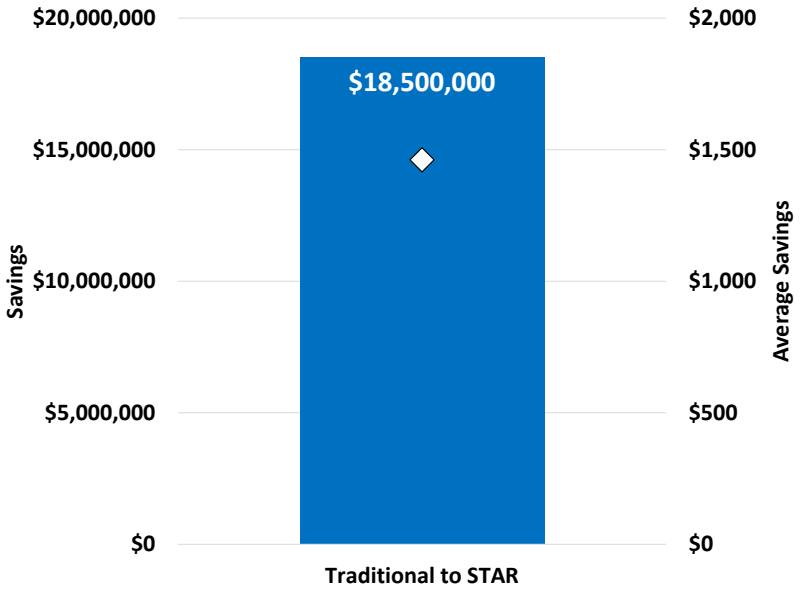



**Figure 9 -** Savings of Members Better Off Moving from Traditional to STAR

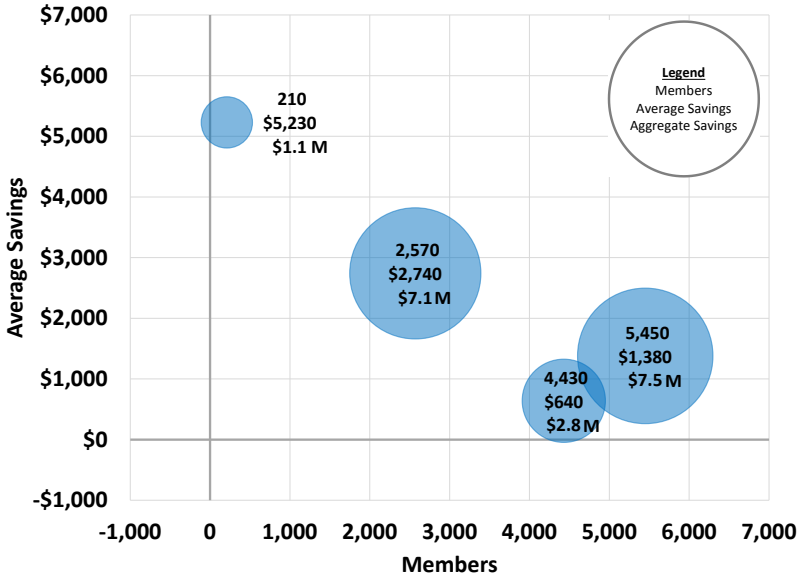
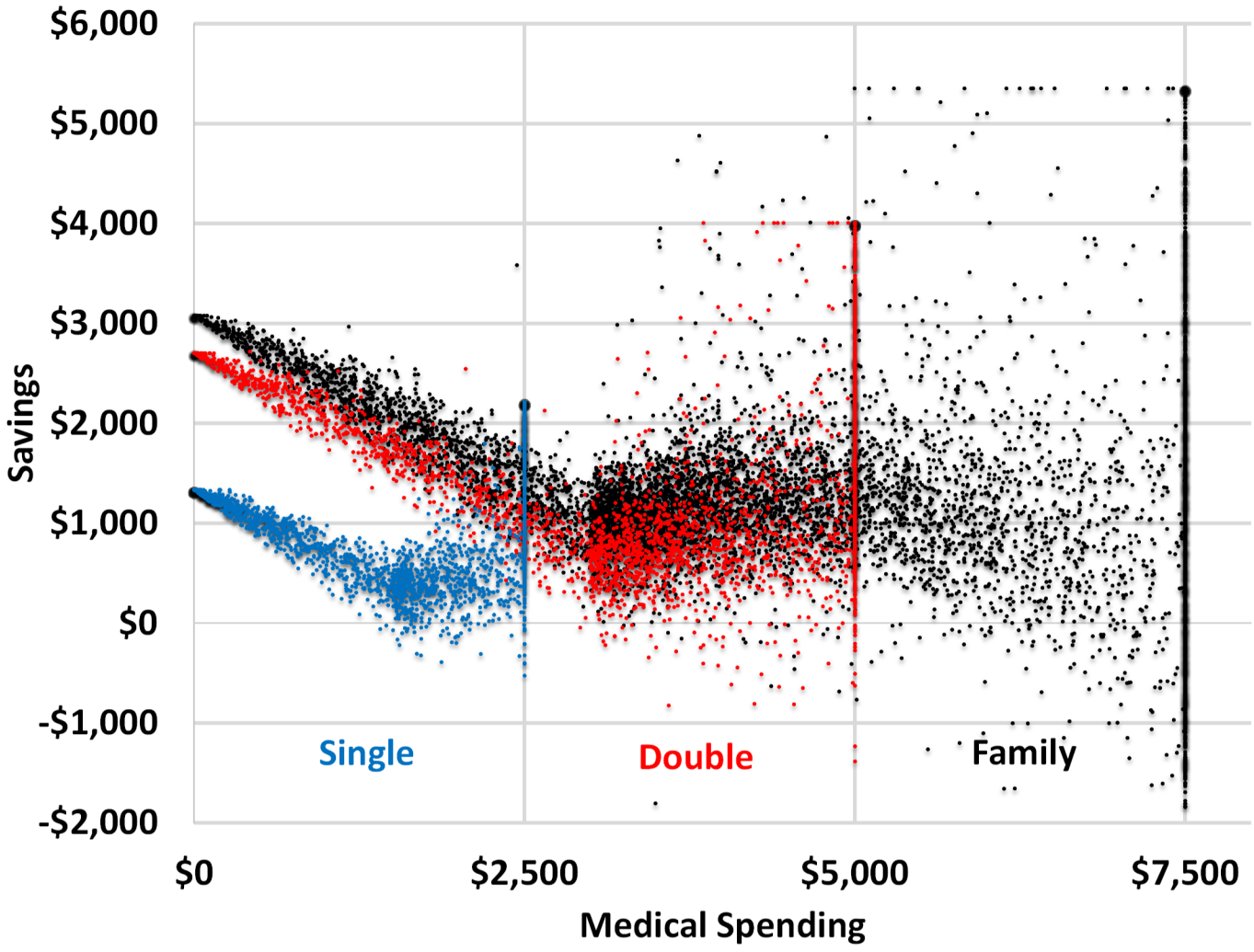



**Figure 9** illustrates the concentration of the possible savings among members who might have benefited financially by moving from Traditional to STAR. A small group of 210 members might have saved $1.1 million, an average of $5,230 among the members saving at least $4,500. A larger group of 2,570 members might have saved $7.1 million, an average of $2,740 among the members saving between $2,000 and $4,500. This is nearly double the average savings. A group of 5,450 members might have saved between $1,000 and $2,000, with aggregate savings of $7.5 million for average group savings of $1,380. A third large group of 4,430 members could each have saved less than $1,000, but together would have saved $2.8 million, for an average group savings

of $640. The graph shows there is a wide distribution of potential saving: 20% would realize an average savings of nearly $3,000 dollars, 40% would realize average savings of near $1,400 and about 35% would realize average savings of around $600.

The savings experienced by members is related to the amount of medical services received, as shown in **Figure 10**. This shows the experience of the members on the Summit or Advantage networks that might have benefited by switching to STAR, separated by Single, Double, and Family coverage. The amount of out-of-pocket spending is on the x-axis and predicted member savings for switching to STAR is on the y-axis. Members using fewer medical services are clearly better off – they would not have paid any premiums,

**Figure 10 -** Possible Dollar Savings for State Employees Had They Moved from Traditional to STAR



would have collected an employer contribution to their HSA, and would have paid little for medical services. The largest savings for those moving to STAR Family plans would be $5,350, under Double plans $4,000, and under Single plans $2,200.

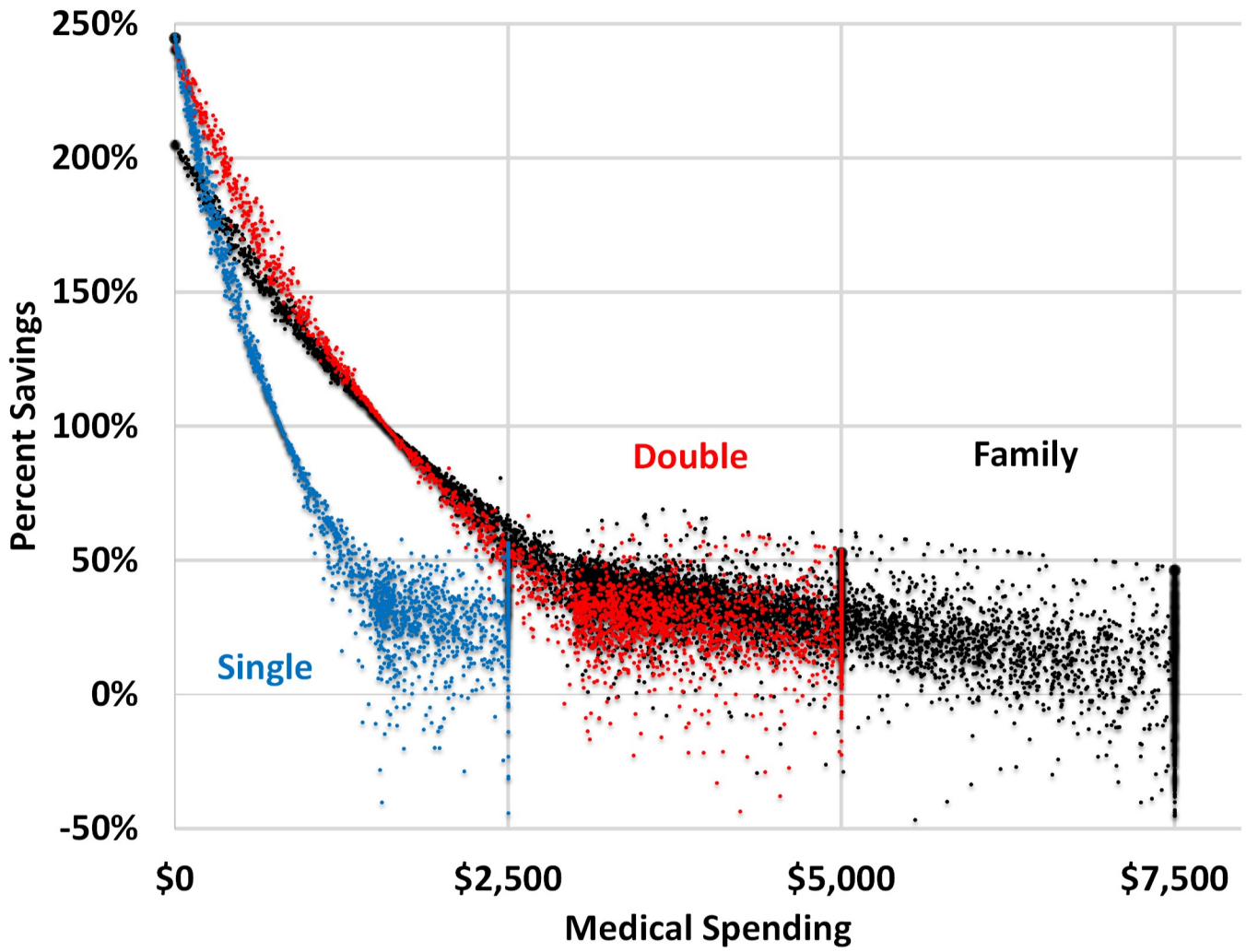
Although members with STAR are responsible for paying the initial medical and pharmacy costs up to the high deductible, the bulk of the high deductible amount is provided to the member via the HSA and premium savings. Members have incentive to seek the most cost-effective medical care because they get to retain a share of the savings they generate. For example, if a member needed an MRI of the lower back, they might use the PEHP Cost and Quality Tool to see a range of providers that charge anywhere between $300 and $1,800 for the same service. The member who had not yet reached the deductible and had no further care during the fiscal year, could have saved $1,500 by choosing the provider who charged the lower cost for the identical service.

As the graph in **Figure 10** shows, savings decrease in a predictable fashion for those with increasing medical costs (there are still some medical services that are covered 100% by PEHP even when the deductible has not been met, e.g. flu shots). That nearly all of the members still retain savings, even with significant medical spending, shows that the combined savings from not paying premiums and receiving the employer HSA contribution amount to more than the high deductible in most cases. Those few cases in which savings is less than zero have relatively high spending, but the benefits are structured in such a way under Traditional that individuals within the plan can reach their out-of-pocket maximums for concentrated spending on particular types of care, while other members with high spending still see savings moving to STAR because their mix of medical care is different.

*The average employee in the State of Utah earns roughly $45,000. Members who switch from Traditional to STAR, while receiving identical medical care, could experience average savings roughly equivalent to a 3% pay raise.*

**Figure 11** shows that hundreds of members on Traditional had very little consumption of medical services and might have saved over 200% of the amount they spent on medical care in FY2015 by moving to STAR. In addition, over 2,000 members, or 16%, on Traditional had medical costs which were low enough that they would likely have saved more than 100% of the amount they spent on medical care in FY2015 by moving to STAR. These savings would be the result of the members retaining their entire premium amount, as well as some or all of the employer's HSA contribution. Even in cases where members spent more than the employer's HSA contribution, the vast bulk of members would have realized significant savings.

## **Figure 11 -** Possible Percentage Savings for State Employees Had They Moved from Traditional to STAR



In cases where members reached their out-of-pocket maximums, most would still have likely realized significant savings had they moved from Traditional to STAR. The vertical bands in **Figures 10 and 11** show the range of savings expected for those members who would have realized their out-of-pocket maximum while on STAR. The range of savings is due to the differences in how out-of-pocket maximums are reached between STAR and Traditional.

## Finding 2 – Concentrated spending on extensive medical care, such as high value prescriptions, would likely have kept almost 4% of state employees enrolled on the Traditional plan from experiencing a savings by moving to STAR plan.

Our investigation of the small proportion of members (4% or 510) that would not have experienced potential savings by moving to the STAR plan showed that it was due to concentrated and significant spending on some types of medical care in which members hit out-of-pocket maximums for a particular type of care, without hitting other out-of-pocket maximums. This results from differences in when out-of-pocket maximums are reached for particular types of care between Traditional and STAR for FY2015. PEHP reported that the members who would not have benefited by moving from Traditional to STAR had significant medical expenditures which exceeded the out-of-pocket maximum for the STAR plan while many also had significant drug costs. The design of the two plans leads to this outcome mostly for Family type plans as compared with Single and Double plans. During the period tested, members on Traditional had several out-of-pocket maximums of varying amounts for pharmacy, specialty pharmacy, medical, and per-individual maximums while the high deductible plans had a single out-of-pocket maximum.

A member on Traditional Family with significant drug purchases of $20,000 under the pharmacy benefit, and $3,200 of medical care, would be better off remaining on Traditional (see **Appendix A and B** for a numeric summary to compare each plan's features). On Traditional, this member's spending could be $5,545, consisting of: premiums of $1,495, a pharmacy deductible of $200, a medical deductible of $500, co-pays of $50, and a coinsurance of $3,300 before reaching the pharmacy out-of-pocket maximum of $3,000. Under STAR, the same member consuming the same medical care would spend $5,916, $371 more than on Traditional, consisting of: the high deductible of $3,000 and the 25% coinsurance (same between Traditional and STAR) for preferred brand name drugs until they reached the overall out-of-pocket maximum of $7,500, less the employer contribution of $1,584. However, if this member continued to spend on medical care within the

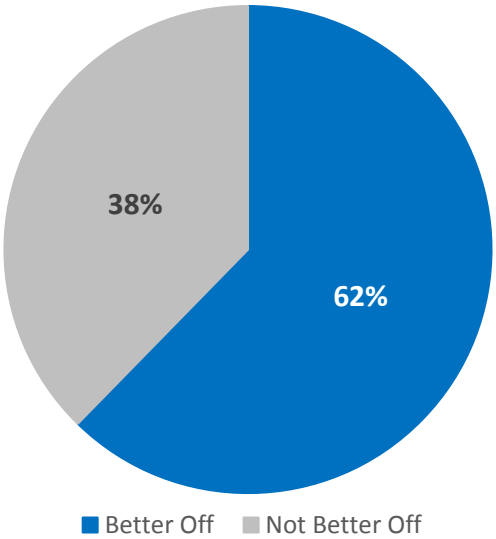
family, it would cost nothing to the member on STAR, but the member on Traditional would have to continue paying a 20% cost share until reaching the other out-of-pocket maximums. Some members in this situation, depending on the order of claims and the composition of care within the family could still be better off under STAR.

The Legislature's passage of joint resolutions directing PEHP to expand options for employee medical plans reveals a desire to grant state employees more flexibility in managing their medical care under a high deductible health plan. If the State's goal is to improve the certainty of the financial outcomes resulting from switching to STAR, policy makers should align plan features such as the prescription drug program between the plans to eliminate this uncertainty. Knowing whether STAR is a plan with lower annual costs to members, in all cases, would be relevant information to the thousands of members still participating in the plan.

## Finding 3 – About 60% of state employees on the STAR plan might have saved money if they had switched to Utah Basic Plus, but greater uncertainty regarding future medical spending likely limits adoption.

Although the amount of savings that would be experienced by members moving from STAR to Basic is less dramatic compared to those moving from Traditional to STAR, there would still be a large percentage of members who would experience a savings. **Figure 12** shows that 62% of the members on STAR would likely have saved money had they switched to Basic.

**Figure 12 -** Financial Position of Members Had They Moved from Traditional to STAR



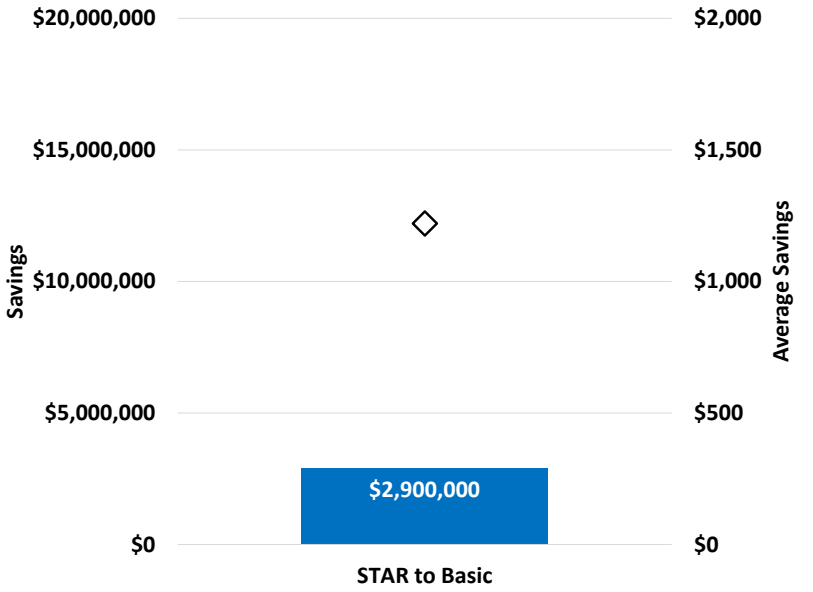

The difference in plan design between Basic and STAR is greater than those between STAR and Traditional. Under Basic, employers contribute to a member's HSA account more than double the amount contributed under STAR. However, Basic is an essential benefit plan, covering fewer services than the other plans. In addition, it has 30%

cost sharing for most services instead of 20%. Basic also has deductibles that are nearly twice as high as the other plans.

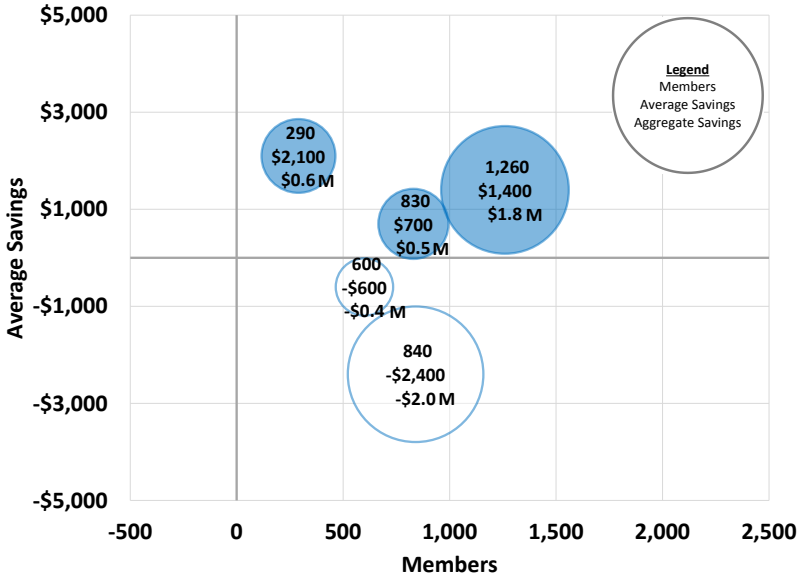
**Figure 13** shows that those who would have benefited by switching from STAR to Basic might have saved an aggregate of $2.9 million for an average savings for these members of $1,220.

The concentration of the financial impacts among members had they moved from STAR to Basic is illustrated in **Figure 14**. It shows that 1,260 members might have saved an average of $1,400, 290 members might have saved an average of $2,100, while the remaining 20% of members would have saved around $700. The gains and losses are asymmetric — if little care is consumed gains are large, but if a large amount of care is consumed members would be better off under STAR. This is a feature of an essential health plan design, as reflected in the hypothetical situations considered in **Figures 4 through 6**. They show that when little medical care is consumed members on Basic would save more money. However, at a certain point, when enough medical care is consumed, the member would have spent less for the same care had they stayed on STAR instead of Basic. The members on Basic should expect to consume little medical care, which allows them to build larger balances over time in their HSA accounts. If in a given year they spend more for medical care than expected, they would have larger reserves to pay for the additional care. This could lead

## **Figure 13 -** Savings of Members Better Off Moving from STAR to Basic




## **Figure 14 -** Distribution of Financial Impact of Members Had They Moved from STAR to Basic



to members deterring non-emergency medical care while on Basic, building large HSA balances, then switching to STAR for medical care that can be planned years in advance. Young, healthy employees, not planning on having children, would likely benefit the most from the design of Basic, as they have less risk of incurring medical costs and could grow HSA contributions over an extended period of time.

Less than 1% of members have adopted Basic. This may be a function of risk tolerance. If the State desires more members to switch to such a plan, policy makers should target those members who would likely benefit from such a plan design. While features of the plan may be fixed by law according to minimum standards set by the Federal Government, whatever features that could be changed to mitigate some risk associated with the essential benefit plan, could lead to higher adoption rates. Such a shift of the relative rewards and risks, while preserving or increasing employee engagement, could lead to increased member participation in the Utah Basic Plus plan.

## Recommendation 1 - Create HSA-equivalent options for members who do not qualify for HSA accounts per federal rules.

Some members would gain little benefit from switching to STAR if they are ineligible to receive HSA contributions per federal rule. Creating an actuarially equivalent benefit for members that will not qualify for an HSA per federal rule could allow the members who want to switch to STAR the option without facing financial losses. Two possible options would be to deposit the HSA-equivalent amount of money into a Health Reimbursement Account or a Flex Spending Account.

## Recommendation 2 - Align plan designs so that the STAR plan always results in a better financial outcome than the Traditional plan.

Employees from the State of Utah could realize substantial savings by adopting higher deductible medical plans as currently designed. To make the STAR plan unambiguously better than the Traditional plan, policy makers should align plan features like deductibles or co-insurance rates between both plans and evaluate how shifting out-of-pocket maximums will affect members.

## Recommendation 3 - Target the Basic plan to low risk employees or employees who are more risk tolerant.

If the State desires more participation from employees in the management of their medical care, then policy makers should target the Basic plan, with its higher deductible and higher HSA employer contribution, to employees with a low risk of medical care and to those employees who are willing to accept greater risk in exchange for greater control of medical spending and a greater possibility of savings. Also, shifting the relative rewards and risks of the Basic plan within given constraints, while preserving or increasing employee engagement, could lead to increased member participation. This could include: raising deductibles while increasing HSA contributions, altering co-insurance rates, or changing out-of-pocket maximums.

# Appendix A - PEHP Health Plan Information for Fiscal Year 2015

## Single Plans

| Category | Traditional | STAR | Basic |
|---|---|---|---|
| **State of Utah** | | | |
| Premium | $4,888 | $4,096 | $3,067 |
| HSA Contribution | $0 | $792 | $1,821 |
| Total: | $4,888 | $4,888 | $4,888 |
| **Employee Share** | | | |
| Summit / Advantage Premium | $543 | $0 | $0 |
| Premium & HSA Savings | $0 | $1,335 | $2,364 |
| **Deductibles** | *$350* | $1,500 | $3,000 |
| medical | $250 | | |
| pharmacy | $100 | | |
| **Out-of-Pocket Maximums** | $9,100 | $2,500 | $6,050 |
| medical | $2,500 | | |
| pharmacy | $3,000 | | |
| specialty pharmacy | $3,600 | | |

## Double Plans

| Category | Traditional plan | Traditional individual | STAR | Basic |
|---|---|---|---|---|
| **State of Utah** | | | | |
| Premium | $10,079 | | $8,495 | $6,437 |
| HSA Contribution | $0 | | $1,584 | $3,643 |
| Total: | $10,079 | | $10,079 | $10,079 |
| **Employee Share** | | | | |
| Summit / Advantage Premium | $1,120 | | $0 | $0 |
| Premium & HSA Savings | $0 | | $2,704 | $4,762 |
| **Deductibles** | *$700* | *$350* | $3,000 | $6,000 |
| medical | $500 | $250 | | |
| pharmacy | $200 | $100 | | |
| **Out-of-Pocket Maximums** | *$18,200* | *$9,100* | $5,000 | $12,100 |
| medical | $5,000 | $2,500 | | |
| pharmacy | $6,000 | $3,000 | | |
| specialty pharmacy | $7,200 | $3,600 | | |

## Family Plans

| Category | Traditional plan | Traditional individual | STAR | Basic |
|---|---|---|---|---|
| **State of Utah** | | | | |
| Premium | $13,456 | | $11,872 | $9,813 |
| HSA Contribution | $0 | | $1,584 | $3,643 |
| Total: | $13,456 | | $13,456 | $13,456 |
| **Employee Share** | | | | |
| Summit / Advantage Premium | $1,495 | | $0 | $0 |
| Premium & HSA Savings | $0 | | $3,079 | $5,138 |
| **Deductibles** | *$700* | *$350* | $3,000 | $6,000 |
| medical | $500 | $250 | | |
| pharmacy | $200 | $100 | | |
| **Out-of-Pocket Maximums** | *>$27,300* | *$9,100* | $7,500 | $12,100 |
| medical | $7,500 | $2,500 | | |
| pharmacy | >$9,000 | $3,000 | | |
| specialty pharmacy | >$10,800 | $3,600 | | |

# Appendix B - PEHP Health Plan Information for Fiscal Year 2016

## Single Plans

| Category | Traditional | STAR | Basic |
|---|---|---|---|
| **State of Utah** | | | |
| Premium | $5,128 | $4,336 | $3,307 |
| HSA Contribution | $0 | $792 | $1,821 |
| Total: | $5,128 | $5,128 | $5,128 |
| **Employee Share** | | | |
| Summit / Advantage Premium | $570 | $0 | $0 |
| Premium & HSA Savings | $0 | $1,362 | $2,391 |
| **Deductibles** | *$350* | $1,500 | $3,000 |
| medical | $350 | | |
| pharmacy | $0 | | |
| **Out-of-Pocket Maximums** | $3,000 | $2,500 | $6,050 |
| medical | combined | | |
| pharmacy | | | |
| specialty pharmacy | | | |

## Double Plans

| Category | Traditional plan | Traditional individual | STAR | Basic |
|---|---|---|---|---|
| **State of Utah** | | | | |
| Premium | $10,573 | | $8,990 | $6,931 |
| HSA Contribution | $0 | | $1,584 | $3,643 |
| Total: | $10,573 | | $10,573 | $10,573 |
| **Employee Share** | | | | |
| Summit / Advantage Premium | $1,175 | | $0 | $0 |
| Premium & HSA Savings | $0 | | $2,759 | $4,817 |
| **Deductibles** | *$700* | *$350* | $3,000 | $6,000 |
| medical | $700 | $350 | | |
| pharmacy | $0 | $0 | | |
| **Out-of-Pocket Maximums** | $6,000 | $3,000 | $5,000 | $12,100 |
| medical | combined | combined | | |
| pharmacy | | | | |
| specialty pharmacy | | | | |

## Family Plans

| Category | Traditional plan | Traditional individual | STAR | Basic |
|---|---|---|---|---|
| **State of Utah** | | | | |
| Premium | $14,115 | | $12,531 | $10,473 |
| HSA Contribution | $0 | | $1,584 | $3,643 |
| Total: | $14,115 | | $14,115 | $14,115 |
| **Employee Share** | | | | |
| Summit / Advantage Premium | $1,569 | | $0 | $0 |
| Premium & HSA Savings | $0 | | $3,153 | $5,211 |
| **Deductibles** | *$700* | *$350* | $3,000 | $6,000 |
| medical | $500 | $250 | | |
| pharmacy | $200 | $100 | | |
| **Out-of-Pocket Maximums** | $9,000 | $3,000 | $7,500 | $12,100 |
| medical | combined | combined | | |
| pharmacy | | | | |
| specialty pharmacy | | | | |

# Appendix C - Comparison of Member Costs Across Medical Plans

**Figure A** shows the total costs faced by members with Single coverage under Traditional, STAR, and Basic. *Scenario 1* shows a member with Single coverage who has two doctor's visits and fills three prescriptions. Under Traditional, the member pays $883 for the care received. The bulk of the total cost comes from the bi-weekly premiums. The member barely reaches the medical and pharmacy deductible, and pays a 25% coinsurance for a brand name medication. The member with STAR or Basic receive more in HSA contributions than they pay for the full cost of the care they receive. The member on STAR is better off by $1,175 and the member on Basic is better off by $2,204.

In *Scenario 2*, the member with Single coverage goes to the doctor and receives a prescription once a month. This member would reach the medical and pharmacy deductible under Traditional, and the high deductible under both STAR and Basic. The member in this situation is $448 better off under STAR and $314 better off under Basic. However, this is not the only benefit, the member on STAR is only an additional $1,500 away from reaching the out-of-pocket maximum whereas the member on Traditional is many thousands of dollars away from reaching that cap.

## **Figure A -** Single Plan Total Cost Example

**Scenario 1 - Minor Medical Care**

2 doctor's visits @ $200, 3 prescriptions @ $100

| **Event** | **Member Cost/(Benefit)** | | |
|---|---|---|---|
| (+) cost / (-) benefit | Traditional | STAR | Basic |
| (-) State HSA contribution | $0 | ($792) | ($1,821) |
| (+) Employee Premium | $543 | $0 | $0 |
| Doctor | | | |
| (+) toward deductible | $200 | $200 | $200 |
| Prescriptions | | | |
| (+) toward deductible | $100 | $300 | $300 |
| (+) coinsurance | $40 | $0 | $0 |
| **Total** | $883 | ($292) | ($1,321) |
| **Difference from Traditional** | **$0** | **($1,175)** | **($2,204)** |

**Scenario 2 - $3,000 in Medical Care**

12 doctor's visits @ $125, 12 prescriptions averaging $125 each

| **Event** | **Member Cost/(Benefit)** | | |
|---|---|---|---|
| (+) cost / (-) benefit | Traditional | STAR | Basic |
| (-) State HSA contribution | $0 | ($792) | ($1,821) |
| (+) Employee Premium | $543 | $0 | $0 |
| Doctor | | | |
| (+) toward deductible | $250 | $750 | $1,500 |
| (+) toward copay | $250 | $0 | $0 |
| (+) toward coinsurance | $0 | $150 | $0 |
| Prescriptions | | | |
| (+) toward deductible | $100 | $750 | $1,500 |
| (+) toward coinsurance | $350 | $188 | $0 |
| **Total** | $1,493 | $1,046 | $1,179 |
| **Difference from Traditional** | **$0** | **($448)** | **($314)** |

## **Figure B -** Double Plan Total Cost Example

**Scenario 3 - $7,000 in Medical Care**

both individuals: 4 doctor's visits @ $100, a specialty visit @ $150, monthly prescriptions @ $200, and $550 screening procedures

| **Event** | **Member Cost/(Benefit)** | | |
|---|---|---|---|
| (+) cost / (-) benefit | Traditional | STAR | Basic |
| (-) State HSA contribution | $0 | ($1,584) | ($3,643) |
| (+) Employee Premium | $1,120 | $0 | $0 |
| Doctor | | | |
| (+) toward deductible | $500 | $700 | $1,100 |
| (+) toward copay | $150 | $0 | $0 |
| (+) toward coinsurance | $0 | $80 | $0 |
| Prescriptions | | | |
| (+) toward deductible | $200 | $2,300 | $4,800 |
| (+) toward coinsurance | $1,150 | $625 | $0 |
| Procedures | | | |
| (+) toward deductible | $0 | $0 | $100 |
| (+) toward coinsurance | $220 | $220 | $300 |
| **Total** | $3,340 | $2,341 | $2,658 |
| **Difference from Traditional** | **$0** | **($999)** | **($682)** |

**Scenario 4 - $25,000 in Medical Care**

individual 1: 2 doctor's visits @ $100, 2 prescriptions @ $200
individual 2: 4 doctor's visits @ $100, 20 specialty visits @150, 15 prescriptions averaging $400, 3 procedures @ $5,000

| **Event** | **Member Cost/(Benefit)** | | |
|---|---|---|---|
| (+) cost / (-) benefit | Traditional | STAR | Basic |
| (-) State HSA contribution | $0 | ($1,584) | ($3,643) |
| (+) Employee Premium | $1,120 | $0 | $0 |
| Doctor | | | |
| (+) toward deductible | $450 | $1,800 | $2,700 |
| (+) toward copay | $740 | $0 | $0 |
| (+) toward coinsurance | $0 | $300 | $270 |
| Prescriptions | | | |
| (+) toward deductible | $200 | $1,200 | $1,800 |
| (+) toward coinsurance | $1,500 | $700 | $1,380 |
| Procedures | | | |
| (+) toward deductible | $0 | $0 | $0 |
| (+) toward coinsurance | $1,760 | $1,000 | $4,500 |
| Beyond out-of-pocket max | $1,240 | $2,660 | $0 |
| **Total** | $5,770 | $3,416 | $7,008 |
| **Difference from Traditional** | **$0** | **($2,354)** | **$1,238** |

The scenarios in **Figure A** also hold for the members with Double coverage. When members receive little medical care, they are always better off with the high deductible plans. **Figure B** shows two scenarios where members receive much more medical care, but are still better off under high deductible plans. In *Scenario 3*, both individuals see doctors regularly and take prescriptions each month. They both receive a screening procedure. The member on STAR is better off by $999, while the member on Basic saves $682 compared with Traditional.

Even under *Scenario 4*, a catastrophic medical scenario where one individual on the plan sees many specialists and undergoes many procedures, STAR costs less than Traditional—by $2,354. The member hits the out-of-pocket max on Traditional and STAR, but not Basic. This highlights the increased risk of Basic, even when the medical care is fully covered under this essential benefit plan.

**Figure 6** of the report shows the vast bulk of members enrolled in Family plans experience the same types of scenarios presented in **Figures A and B**. However, the few cases in which members on Traditional Family were still better off have characteristic features.

**Figure C** presents this type of case in more detail. In *Scenario 5*, a member enrolled on the Family plan has high spending on prescriptions, but low spending on other types of care. This is often possible when individuals are diagnosed with chronic conditions that require little in the way of procedures or doctor visits, but are treated most effectively with costly preferred brand name drugs lacking generic alternatives. As the figure shows, member costs are in the $5,000 to $7,000 range with the member on Traditional better off by $591 compared with STAR and $1,633 compared to Basic.

*Scenario 6* is another extreme example in which an individual on a Family plan has high medical spending with relatively little prescription spending. Traditional under this circumstance is advantageous because an individual in the family can reach the individual out-of-pocket maximum of $2,500 quickly while members on other plans continue to pay coinsurance until the high deductibles are met.

## **Figure C -** Family Plan Total Cost Example

**Scenario 5 - High Prescription Costs, $20,000**

family: 5 doctor's visits @ $100, 5 prescriptions @ $200,
an individual: a $500 screening, prescriptions of $19,000

| **Event** (+) cost / (-) benefit | **Member Cost/(Benefit)** Traditional | STAR | Basic |
|---|---|---|---|
| (-) State HSA contribution | $0 | ($1,584) | ($3,643) |
| (+) Employee Premium | $1,495 | $0 | $0 |
| Doctor | | | |
| (+) toward deductible | $500 | $400 | $400 |
| (+) toward copay | $0 | $0 | $0 |
| (+) toward coinsurance | $0 | $20 | $30 |
| Prescriptions | | | |
| (+) toward deductible | $200 | $2,600 | $5,700 |
| (+) toward coinsurance | * $3,000 | $4,350 | $4,290 |
| Procedures | | | |
| (+) toward deductible | $0 | $0 | $0 |
| (+) toward coinsurance | $100 | $100 | $150 |
| Beyond out-of-pocket max | $4,200 | $0 | $0 |
| **Total** | $5,295 | $5,886 | $6,928 |
| **Difference from Traditional** | **$0** | **$591** | **$1,633** |

**Scenario 6 - High Medical Care, $40,000**

family: 5 doctor's visits @ $100, 5 prescriptions @ $200,
an individual: $37,000 hospital stay, prescriptions of $2,000

| **Event** (+) cost / (-) benefit | **Member Cost/(Benefit)** Traditional | STAR | Basic |
|---|---|---|---|
| (-) State HSA contribution | $0 | ($1,584) | ($3,643) |
| (+) Employee Premium | $1,495 | $0 | $0 |
| Doctor | | | |
| (+) toward deductible | $500 | $500 | $500 |
| (+) toward copay | $0 | $0 | $0 |
| (+) toward coinsurance | $0 | $0 | $0 |
| Prescriptions | | | |
| (+) toward deductible | $200 | $500 | $3,000 |
| (+) toward coinsurance | $700 | $625 | $0 |
| Procedures | | | |
| (+) toward deductible | $0 | $2,000 | $2,600 |
| (+) toward coinsurance | * $2,500 | $3,875 | $6,000 |
| Beyond out-of-pocket max | $5,550 | $3,125 | $4,320 |
| **Total** | $5,395 | $5,916 | $8,458 |
| **Difference from Traditional** | **$0** | **$521** | **$3,063** |

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# PEHP

# Response

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We very much appreciate the considerable work of the Office of the Utah State Auditor in producing Analysis Report No. AR 16-01, Opportunities for Financial Benefit Using High Deductible Medical Plans and for providing an opportunity to comment.

As the Report finds, the vast majority of state employees would be financially better off on one of PEHP's HSA-qualified plans than on our Traditional plan. This is largely due to the state's commitment to provide a significant, actuarially equivalent HSA contribution to employees on HSA-qualified plans and the absence of an employee premium.

We believe further that HSA-qualified plans can encourage state employees to view healthcare expenditures more personally, seek greater value for their healthcare dollars, and ultimately help preserve current benefit levels. Accordingly, PEHP makes every effort to educate state employees on the benefits of our HSA-qualified plans and to provide tools to support value-based healthcare decisions.

The Report makes three policy-related recommendations for increasing employee enrollment in an HSA-qualified plan, each of which requires some level of legislative action. We have no concerns with our ability to implement any of these recommendations and, as with matters of policy generally, would welcome the opportunity to provide whatever assistance may be helpful in the deliberative process.

We again appreciate the work of the Office of the Utah State Auditor in producing this Report.

Very Truly Yours,

R. Chet Loftis
Managing Director